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ABSTRACT

This final report presents the recommendation of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) Planning Panel that a National Credentialing Organization for Alcoholism Counselors be established. Implementation plans for the National Credentialing Organization are presented in three phases. Funding and staffing are discussed. A five-year budget proposal is outlined. An appendix includes an interim report on problems and issues associated with the credentialing of alcoholism treatment personnel. The NIAAA Planning Panel believes that the creation of a National Credentialing Organization for alcoholism counselors can, to a significant degree, achieve the following: (1) improve the care of alcoholic patients; (2) provide recognition for the profession of alcoholism counseling; and (3) provide third-party payers assurances of quality care to alcoholic patients. (Author/JLL)

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FINAL REPORT

OF THE

ADAMHA/NIAAA PLANNING PANEL

ON

ALCOHOLISM COUNSELOR CREDENTIALING

February, 1977

U S DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

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The focus of the credentialing of alcoholism counselors stems from the need to assure quality care to alcoholic people, to obtain third-party payments, and to provide recognition to the counselors for their valuable services. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) initiated activity in 1973 to determine the competencies of alcoholism counselors as well as the possibilities of obtaining third-party payments. In August of 1974, a contractor's report was submitted to the Institute by Roy Littlejohn Associates, Inc. This report, "Proposed National Standard for Alcoholism Counselors", reflected the work of an advisory board and suggested counselor competencies which would lead to quality care. The report also recommended the establishment of a national credentialing board; the report proposed that the credentialing be voluntary. The NIAAA accepted the report but did not implement the recommendations contained. It was the Institute's position that credentialing was an issue for the states at that time and that it would be inappropriate in view of the HEW's moratorium on licensure activities to recommend implementation of the standards proposed in the Littlejohn report.

In the Fall of 1975, the need for credentialing alcoholism counselors was stimulated by activities in a variety of forums. As a result of this activity, ADAMHA and NIAAA established a Planning Panel to (1) identify the issues relevant to credentialing alcoholism counselors and (2) make recommendations to the field of alcoholism as to how it should proceed with the credentialing issue. The Planning Panel held its first meeting January 27-28, 1976, to consider the issues relevant to the credentialing of alcoholism counselors.

Prior to its first meeting, the Planning Panel requested a large number of national organizations and individuals in the alcoholism treatment field to help

identify and isolate the primary issues of concern to the field in the credentialing process. The issues discussed by the Planning Panel as a result of this effort included:

1. The need to credential alcoholism personnel.
2. The requirements for credentialing including the knowledge, skills and attitudes required of alcoholism personnel.
3. The present status of credentialing of alcoholism personnel.
4. The present status of accreditation of facilities and the need for personnel standards.
5. The status of certification of other health professionals in the United States today.
6. The need for recognition by third-party payors considering reimbursement for services rendered to alcoholics.
7. The problems associated with a national credentialing organization.
8. The adequacy of the Littlejohn report as a basis for the credentialing of alcoholism personnel.

During the two day Planning Panel meeting, it became readily apparent to the Panel members that the credentialing of alcoholism personnel could fulfill three basic needs in the field of alcoholism. These were:

1. Assure the quality of health care provided the alcoholic patient by treatment personnel.
2. Achieve recognition of alcoholism treatment personnel as health professionals.
3. Provide for a mechanism by which third-party payors could compensate personnel or facilities for services provided the alcoholic patient with an assurance that quality care was being rendered.

It was the considered opinion of the Panel that the requirements for credentialing should best be left to an organization which would specify the competencies and develop measures of these competencies. The Panel discussed the interrelationship between facility accreditation and the need for credentialled personnel to function in those facilities. It also believed the Littlejohn

report could be the starting point for standard development but that it would be appropriate to add to, delete or make other changes in the recommendations of the Littlejohn report.

Considerable time was spent in identifying the problems associated with the national credentialing status of other health professions in the United States. It was recognized that while the focus of this Panel was upon alcoholism counselors, bridges should be developed to other professional organizations which might facilitate the development of an organization of alcoholism counselors.

Following its initial meeting, the Planning Panel issued an Interim Report (See Appendix A) which (1) highlighted the material presented at the Panel meeting, (2) provided four alternative mechanisms for the credentialing of alcoholism personnel for consideration by the field and (3) proposed the functions to be performed by a national credentialing organization. The Interim Report was widely circulated to obtain response from individuals and organizations in the field of alcoholism.

Resolution of the areas of concern brought to the Planning Panel's attention by the respondents to the Interim Report was delegated to an ad hoc subcommittee of the Panel. These issues included:

1. The procedure by which the alcoholism counselors on a national certifying board of directors will be selected.

2. The structure and size of the proposed board of directors.

3. The means by which a National Credentialing Board could be implemented, i.e., mechanisms available to initiate the concept of a national credentialing effort.

4. The financial aspects of a National Credentialing Organization, i.e., cost, interim methods of funding, permanent methods of funding and sources of both interim and permanent funding.

In addition, the Panel attempted to clearly define for its own purposes the terms commonly encompassed in credentialing. The Panel defined credentialing as an umbrella type term which included four distinct processes: Accreditation, a process by which standards are set for educational or treatment programs; Certification, which in its purest form is a voluntary standard setting process generally handled by a professional association; Registration, a procedure employed by professional associations or governmental agencies which lists persons on a roster who have met certain minimum prescribed qualifications; and Licensure, a process used by State or Federal Governments to restrict the practice privileges of certain professions to those meeting the minimum requirements established for the professions by legislative act. The States would be encouraged to adopt the type of credential determined to be most appropriate to the needs of their alcoholic people and neither the Planning Panel nor a national organization should attempt to dictate to any State or counselor association the type of credential to be required.

The recommendations of the ad hoc subcommittee were then brought to the Planning Panel for discussion and approval at the final meeting of the Panel in late September, 1976. The recommendation and concomitant activities which follow are those the Panel proposes to the alcoholism field for adoption and implementation.

Recommendation of the Planning Panel: Establish a National Credentialing Organization

The Planning Panel recommends that the field of alcoholism establish, at the earliest possible date, a National Credentialing Organization. The implementation of this concept should proceed in three distinct phases.

Phase I: Interim Board

A. Interim Board Functions

The establishment of a 34-member interim Board of Directors which is representative of the field of alcoholism and whose functions will be to: (1) establish itself as a legal entity; (2) secure the services of an executive director and staff and (3) begin carrying out the functions of the Interim Board as described below. In this phase, it will be necessary to identify a foundation to serve as a "platform" and fiduciary agent for the organization. The members of the Planning Panel agreed to serve as a "bridging group" to assist obtaining temporary funding to appoint the Interim Board of Directors and to be available for advice and consultation for this Board Further details about the fiduciary agent are contained in the Phase III.C. on financing the national credentialing organization.

B. Appoint Interim Board

It is recommended that the Interim Board of Directors have 34 members of the following composition:

Ten (10) practicing alcoholism counselors.

Six (6) technical experts.

Nine (9) representatives from the field of alcoholism.

Three (3) State Alcoholism Directors.

Four (4) representatives from minority organizations.

Two (2) at-large representatives to be chosen by the Panel to assure balance in the Board as to representation of interested persons.

The members of the Interim Board of Directors will be appointed by the NIAAA Planning Panel and will serve until a permanent Board is in place. The Panel will select and appoint the Board members according to the following procedures:

Alcoholism Counselors. In each state the counselor organization will nominate a minimum of four (4) and a maximum of six (6) practicing counselors. Of those nominated, the State Alcoholism Director will select two (2) and forward the names and credentials of those selected to the NIAAA Planning Panel. In those states where there is no identifiable professional organization of alcoholism counselors, the State Director of Alcoholism would be asked to nominate two individuals. Each nominating organization should consider the functions and tasks of the Interim Board in making their recommendations of individuals to serve on the Interim Board. In addition, the nominating group or individual will be asked to give appropriate consideration to the concern for equal male/female representation, minority representation and for demographic characteristics such as rural vs. urban, large cities vs. small cities, etc. The above procedure will result in the nomination of 100 alcoholism counselors from which the five representatives of national alcoholism organization on the Planning Panel and the Panel Chairman will appoint 10 counselors to serve on the Interim Board. Their recommendations will be presented to the full NIAAA Planning Panel for ratification.

Technical Experts. The six technical experts required by the Interim Board (including at least one public member) will be selected by the NIAAA Planning Panel from recommendations received from within the Panel and from other sources.

Representatives from the Field of Alcoholism. The following national organizations will be asked to nominate an individual to serve on the Interim Board of Directors:

-Alcohol and Drug Problem Association of North America
-Association of Halfway House Alcoholism Programs of North America, Inc.
-ALMACA
-Council of State & Territorial Alcoholism Authorities
-National Association of Alcoholism Counselors
-National Council on Alcoholism
-NCCMHC
-Salvation Army
-Volunteers of America

State Alcoholism Directors. The NIAAA Planning Panel will select three (3) State Alcoholism Directors to serve on the Interim Board of Directors.

Minority Representatives. The following organizations or groups will be asked to nominate one individual to serve on the Interim Board of Directors.

NAAP	National Indian Board
Black Caucus	Spanish Commission

At Large Representatives. It is possible that through the selection procedures outlined above there may be a need for additional representation on the Interim Board of Directors to achieve optimum balance of perspectives and experience. If the process does not result in at least 50 percent counselors, ensure representation of program directors and women representatives, the Planning Panel will add necessary counselors and program directors to ensure public and private interests.

Phase II: Transition

A. Establish Executive Committee - Functions

During this phase, the Interim Board of Directors will elect an Executive Committee of the Board consisting of ten (10) members.

It shall be the function of the Executive Committee to act for the Interim as well as the permanent Board. The Panel felt that the 10 member working Executive Committee would be less costly and more efficient. All actions of the Executive Committee would be subject to ratification by the full Board during one of its regular meetings.

B. Establish Subcommittees - Functions

In addition, the Interim Board and/or executive will establish committee subcommittees of the Board to carry out specific functions. These will include (1) a National Credentialing Standards Subcommittee whose task it will be to develop credentialing standards by examining the standards proposed by the Littlejohn report and others currently in operation and to make recommendations to the Executive Committee and/or the full Board; (2) a Subcommittee on the Organizational Structure of State Credentialing Bodies examine current organizational relationships and recommend to the Executive Committee and/or the full Board the structure by which credentialing can be accomplished in the field of alcoholism to achieve the desired goals; (3) a Research and Standards Development Subcommittee which will begin to develop procedures to assess entry level and continued competency and (4) an Information and Education Subcommittee which will provide the requisite communication channels between the Board and alcoholism personnel, legislative bodies, third-party payors, states and other professions.

During Phase II, the Board will also consider and adopt a procedure by which the Interim Board will be phased out and replaced by the permanent Board of Directors.

Phase III: Permanent Status

A. Functions of the Permanent Board

This phase is the permanent phase of operation of the National Credentialing Organization in which it will strive to carry out the functions delineated below.

The functions of the National Credentialing Organization implemented through its interim and permanent Boards of Directors should be those initially adopted by the NIAAA Planning Panel in its deliberations. These functions were based on those described in the publication "Feasibility Study of a Voluntary National Certification System for Allied Health Personnel" issued by the Institute of Public Administration and Robert R. Nathan Associates on March 31, 1974. The Board of Directors should be free to decide which of the functions have highest priority and thus which should be implemented initially. In addition, the Board may adopt other functions as it deems necessary to meet the goals and objectives of the National Credentialing Organization.

B. Functions of the National Credentialing Organization

The functions of the National Credentialing Organization are described in the chart below:

Function	Definition
1. Establish standards for certifying bodies..	Determine criteria, standards, policies, and roles for certifying systems that are responsive to the needs of an evolving health care delivery system; and aid in their implementation. Serve as the agent to advise on standards and processes in the establishment and operation of new certifying systems.

Function	Definition
2. Conduct research.....	Study the methodology of test construction and validation; cost-saving practices in certification procedures; methods for maintaining competence after initial certification; interactions of certification and other forms of credentialing.
3. Collect and disseminate information.....	Encourage the collection, compilation, and dissemination of manpower and credentialing information. Collect, analyze, and disseminate information regarding new technology effecting the occupational structure and credentialing standards for alcoholism counselor personnel.
4. Provide for mediating, cooperative and joint activities.....	Provide a structure within which the member organizations and other parties-at-interest can review and coordinate initial and continuing certification requirements; mediate differences arising from the need to certify new professions or sub-specialties with cross-disciplinary characteristics. Coordinate the development of joint examination programs.
5. To perform a public information role.....	Serve as a common communication arm to various legislative and administrative government agencies, private groups, third-party payors and the public concerning credentialing of alcoholism personnel.
6. Function of education..	Encourage the development of education and training programs for alcoholism counselors.
7. Foster constructive relationships.....	Foster constructive relationships with credentialing efforts of related occupational groups.

C. Financing of the National Credentialing Organization

The Planning Panel believes that the National Credentialing Organization must become a self-sustaining body as quickly as possible. It is necessary to develop a plan which demonstrates

the ability of the organization to attract funds from foundations, counselors and other organizations. Furthermore, the Federal Government should contribute to the start-up costs as well as funds for specific task activities such as the development of competencies, the development of techniques to assess such competencies and the conduct of research into other matters related to credentialing.

Phase 1 Funding. During the organizational period prior to the establishment of the Board of Directors as a legal entity, it will be necessary to obtain the services of an interim fiduciary agent to receive and disburse funds obtained from all sources. The Panel recommends that the Panel Chairman determine whether or not the University of Florida Foundation, Inc., would agree to serve as such a fiduciary agent until such time as the National Credentialing Organization has been established. In addition, communications should be initiated with other private foundations to explore their willingness to serve in this capacity. Irrespective of the fiduciary agent selected, the members of the Planning Panel have agreed to serve until the Interim Board is established. The Panel also recommends that both private and federal support be obtained for the establishment and implementation of the National Credentialing Organization at the earliest possible date. Any funds collected would be disbursed according to the budget recommended on page 14 of this report. Grant and/or contract proposals should be submitted to appropriate foundations and government agencies as early as possible to provide sufficient operational and task oriented funds to meet the goals and objectives established for its Phase I activities. In this

regard, every effort should be made to attract non-federal monies to the credentialing organization to demonstrate to the Federal Government the commitment of the field of alcoholism and related organizations to the counselor credentialing endeavor.

Phase 2 Funding. As early as possible in Phase II, a mechanism should be established whereby the counselors begin to assume a major portion of the operational costs of the National Credentialing Organization. Such income could consist of: (1) an annual or biannual credentialing fee paid by the counselor being credentialed, (2) an applicant's examination fee for initial credentialing or recredentialing, (3) fees derived from the providing examinations to state or other examining bodies, and (4) dues collected from affiliated state or territorial organizations.

In addition to the funds derived by fees for services as described above, the National Credentialing Organization should seek supplemental funding during this phase for its continuing task oriented operations. Both federal and private sources should be considered for contracts and grants to allow the organization to achieve its objectives.

Phase 3 Funding. During this phase of its existence, the National Credentialing Organization should be on the way to independence from federal support for its operational activities. Federal monies would be necessary for task oriented functions and would be obtained on a competitive basis determined by the merit of the proposal and the interest of the funding source in the work product. The concept of eventual financial autonomy should be acceptable by the field of alcoholism and the Federal Government alike.

Summary and Conclusions

The NIAAA Planning Panel recommends that a National Credentialing Organization for Alcoholism Counselors be established. The implementation of the National Credentialing Organization should be accomplished in three distinct phases to allow for the orderly evolution of the organization and its acceptance by the field of alcoholism. To assure that the goals and objectives of National Credentialing Organization are consistent with the needs of the alcoholic patient, the initial Board of Directors should be as representative of the field of alcoholism as is possible, thus allowing for the valued input of interested persons throughout the formative phases of the National Credentialing Organization's development.

The National Credentialing Organization should be as self-supporting as is possible, relying on federal support only for some of its initial start-up costs and for task-oriented projects obtained on a competitive basis.

The NIAAA Planning Panel believes that the desirable goals of: (1) improving the care of alcoholic patients in the United States, (2) providing recognition for the newly emerging profession of alcoholism counseling and (3) providing third-party payors assurances of quality care to alcoholic patients can be achieved, to a significant degree, by the creation of a National Credentialing Organization for alcoholism counselors.

PROPOSED FIVE-YEAR BUDGET FOR THE NATIONAL CREDENTIALING ORGANIZATION

Estimates of income were made for the first five-year period as well as estimates of expense. In regard to income, it was first necessary to estimate the total universe of individuals who might seek credentialing. Two different methods were utilized to estimate the number of individuals seeking credentialing. (1) there are approximately 3,000 alcoholism treatment centers in the United States and an assumption was made that each treatment center should employ three counselors. Assuming an error of plus or minus 10%, the total number of counselors in the United States would be between 8,000 and 10,000. Assuming that no more than 10% would seek credentialing in the first year, the number of applicants would be approximately 900; (2) the NAAC Organization has approximately 1,800 members in 20 states. Extrapolating to the fifty states, total number of counselors in this professional organization would be 4,500. This type of an individual is more likely to seek a credential than the non-affiliated counselor. Assuming that 20% would apply for a credential in the first year, again, 900 applicants would constitute the pool.

In all income estimates, attempts were made to minimize the pool of potential applicants. In this regard, we have also assumed that there would be no increase in the universe of a five-year period of time. In addition, no assumptions were made as to the impact of any national health insurance program or The Health Professions Education Assistance Act.

Income Projections

1977-78 Year 1--

Assume no income to the organization because of the need to develop the organization, select office space, hire staff, etc.
Recognize that it may be possible for some of these tasks to occur before the organization itself is established.

1978-79 Year 2--

Assume in this year that no proficiency examinations will yet be available and that the major function of the organization will be to review the credentials issued by other organizations, states, etc. The organization will charge a $25 fee and provide a 2-year conditional credential.
Assume that 800 individuals will seek the support producing an income of $20,000 to the organization.

$20,000

1979-80 Year 3--

Again assume no proficiency test, but that 1500 individuals will enroll for a $25 fee for the 2-year conditional credential. This will provide the organization with $37,500.

$37,500

1980-81 Year 4—

It is assumed that a proficiency test will now be available (funds for its development will then be obtained through grants and contracts). Believe that the 800 individuals who received conditional credentials in 1978-79 will apply to take the proficiency test as will 1500 new people. The 2300 individuals will be charged $60 each and produce $138,000 for the organization.

$138,000

1981-82 Year 5—

Assume that 3,000 individuals will take the credential test, 1500 from the 1979-80 group and 1500 new. At $60 per test this will produce $180,000 for the organization.

$180,000

Expense Projections

1. First Year Detailed Budget

Salaries and Fringe Benefits

Exec. GS 14-15 equiv.	30,000
Deputy GS 13 equiv.	20,000
Secy GS 7	8,000
Clerk GS 5	7,000
	65,000
FRINGE BENEFITS	9,750
	74,750

Materials & Services

Supplies		
Xerox paper	1,200	(to support 8-9K copies/mo.)
Office Supplies	2,000	
Rental Equipment		
Xerox	5,500	(8-9K copies/mo.)
Other	500	
Books, Pubs, Dues, Subscrips.	1,000	
Equipment Maintenance	300	
Audit/Acct. Servs.	1,200	
Prof. & Tech. Consultation	7,500	(40 da. + travel & p.d. @ $150/da.
Rent 1800 ft. @ $8	14,400	
Telephone $500/mo.	6,000	
Postage $400/mo.	4,800	
Insurance & Bonding	1,700	
Printing	2,000	
	48,100	

Travel

To: ETS, PES, & other such visits 6 @$300	1,800
Staff	
To: National meetings - alcohol, drugs, human services, etc. 5 @ $400	2,000
Staff primarily	
To: States	
20 @ $250	5,000
Board/Exec. committee primarily	
To: Summer schools	
5 x 250	1,250
Board/exec. committee primarily	
One 2-day Board meeting	
35 people x 300.	10,500
Exec. Committee	
10 people @ 300 x 3 meetings	9,000
	29,550

Capital Outlay

Desks, chairs, typewriters, file cabinets, drapes, tables, etc.	$8,000

Personal Services	$ 74,750
Materials and Services	48,100
Travel	29,550
Capital Outlay	8,000
	$160,400

2. Five-Year Projection

	Year 1	Year 2	Year 3	Year 4	Year 5
Salaries & Fringe Benefits	74,750	80,500	87,188	94,163	101,696
Materials & Services	48,100	50,100	52,100	54,100	56,100
Travel	29,550	30,550	31,550	31,550	31,550
Capital Outlay	8,000	1,000	1,000	1,000	1,000
	160,400	162,150	171,838	180 813	190,346

ASSUMPTIONS: +8% per year in salaries plus modest inflationary increases in other categories.

THE COSTS REFLECTED ABOVE WERE BASED ON THOSE ASSOCIATED WITH THE ATLANTA, GEORGIA AREA.

APPENDIX A

INTERIM REPORT OF THE NIAAA PLANNING PANEL ON PROBLEMS AND ISSUES ASSOCIATED WITH THE CREDENTIALING OF ALCOHOLISM TREATMENT PERSONNEL

The problems and issues associated with the credentialing of alcoholism treatment personnel were the subject of the meeting of the NIAAA Planning Panel on January 27 and 28, 1976. Among those issues considered by the Panel were:

1. The need for the credentialing of alcoholism personnel.
2. The requirements for credentialing including the knowledge, skills and attitudes required of alcoholism personnel.
3. The present status of credentialing of alcoholism personnel.
4. The present status of accreditation of facilities and the need for personnel standards.
5. The status of certification of other health professionals in the United States today.
6. The need for recognition by third party payors.
7. The problems and issues associated with a national credentialing organization.
8. The adequacy of the Littlejohn report as a basis for the credentialing of alcoholism personnel.

Prior to the meeting, notification at the meeting and the request for written responses was sent to a large number of national and state organizations directly involved in alcoholism. More than 50 written responses were obtained and disseminated to the committee for their consideration. In addition, the meeting was attended by representatives of many alcoholism organizations and their input was received throughout the two day meeting.

This report serves to summarize a portion of the material submitted to the Panel and more importantly, provide alternative proposals for the credentialing of alcoholism treatment personnel.

Paramount among the basic concerns of the Planning Panel in considering this issue was the need to assure the quality of the health care provided by the alcoholism treatment personnel. Also of major concern to the Panel was the need to provide for recognition of the alcoholism counselor as a health practitioner and to provide for a mechanism by which third party payors could compensate alcoholism programs and personnel for services rendered.

The material which follows in this interim report consists of (1) presentations made by Panel members, (2) the four alternative mechanisms for credentialing as agreed upon by the Panel and (3) the agreed upon functions to be performed by such a credentialing organizations.

A STATE PROGRAM DIRECTOR'S POINT OF VIEW*

It was mentioned earlier that the Department of Health, Education, and Welfare senses the confusion and the barriers that the traditional method of state licensure has caused in this country. In Minnesota, we began our present effort of reform with the question of whether the traditional way of licensing health professionals was causing barriers to the facilitation of a coordinated and interdependent delivery team. The answer to that question in the early 70's was "yes". It was "yes" because (1) our legislature, and probably other legislatures around the country, granted licenses without benefit of study or criteria for determining whether for public protection an occupational group which asks for a license should be a licensed group, (2) licensure prohibits persons not so licensed from carrying out the licensed practices, thus carves the service terrain into isolated, fragmented pieces, and (3) it was difficult and expensive for boards to update their statutes through the legislative process as often as practice was changing.

There has also been major concern that with each legislative session, 4 or 6 new groups present themselves for licensure. By the definition of licensure, there's very little turf left to carve up. Certainly a system had evolved which leaves no room for subscitutability, and which makes it unacceptable to recognize that there is overlap in functions or that functions are shared either within an occupational family or between occupational families.

When we looked at the meaning of the word "credentialing", we found that it was generally an umbrella term which covered four processes. The processes are: accreditation, which sets standards for the educational programs; certification, which in its pure form is a voluntary standard setting process generally handled by the professional associations; registration, a process used by State government or by professional associations, which lists people on a roster who have met certain predetermined qualifications; and then licensure, which is a term used generally only by the State and which, as I said before, protects both the occupational title and the scope of functions the group holding that title can perform.

As we try to look, then, at the purest definitions of those four credentialing terms, and try to look at the problems of traditional licensing and come up with a system which would overcome the problems of the past and begin to work on into the future, Minnesota passed legislation authorizing the development of a system we call administrative registration. The definition that is being used for registration is that those practitioners who will be the only persons permitted to use a designated title are listed on an official roster after having met predetermined qualifications. The administrative rules of the State will cover the groups' competencies and the registration of another title may certainly include some of the same competencies of this particular group. Descriptive information on the credentialing decision making process is available.

Public and Private Partnership at Federal, National and State Levels

As a director of a State program looking at this whole field of credentialing, it seems to me that we are dealing in a partnership and there are functions best carried out at various levels. Implementation and enforcement are best carried out at the State level. We would, however, use national standards and assessment mechanisms if they existed in an occupational area for examining candidates

*Presented by Corrine W. Larson

and for determining equivalency of life experiences. When we look at the way other health professions have set standards, we traditionally see that it is the professional association which has generally been the group best able to set those standards. In this day of accountability, it seems to me, however, that the standard setting group must be designed in such a way that the standards it sets are for the public good. We have had instances in the past where standards may have served to protect the credentialed group rather than the public.

Why Credential?

Let me just say a couple of words about how I feel as to why we should credential at all. It seems to me that the first reason for credentialing is protection of the public. The public needs, certainly in this day and age when there are public dollars going into most treatment programs, to know that the services that they are receiving are appropriate for both their delivery and their diagnosis.

Secondly, the public needs to be able to identify the qualified practitioner. I came upon that in a very practical way. In my program, we have ten licensing boards who license 16 licensed groups in our State; and through our new process, we handle the administrative credentials for several other groups. My staff handles the back-up phones for all of these occupations. I did not come today prepared to document the number of phone calls per day or the number per week. But there are a great number of phone calls from the general public just asking such simple questions as, "How should I select a 'good' marriage counselor?" or "How do I recognize a qualified psychologist?" How to identify is a very important public question.

I think the third reason for credentialing is in terms of its public policy and resource allocation implications. This is not a traditional function, practice or attitude of existing licensing boards, but it does seem to me that we are at a point in time where we need to have some information on our practitioners for decision making. We need to be able to know who's out there doing what as well as what is needed in order to do a better job of resource allocation, for both educational and services programming. Those, in my mind, are the three major reasons for credentialing.

You might be wondering if there are better mechanisms for getting at quality assurance than credentialing. I dare say that by now, everyone in this room probably realizes that those four credentialing terms all apply to what I would say is the front end of the quality assurance system. If I look at the umbrella of quality assurance, I see that that which really counts is over here at the outcome for the client or the patient. He is better as a result of those things occurring to him. At this point in history in the United States, we don't have very good outcome measures. We're just beginning to get a feel for some of them. Because of that, we have a series of back-up quality assurance systems, none of which are doing a good enough job. Two back-up systems are either in credentialing the individual (licensure, registration, certification) and/or credentialing the educational program (accreditation). Through meeting standards for the educational program, we are somehow saying that we believe that these series of inputs will result in a better product: Because he was a product of a certain educational experience under the direction of qualified faculty, he is somehow better than if he was not.

Credentialing the individual has in the past been really just a verification of that education. We are beginning to be a little smarter now and are also looking at alternatives. In some of the occupational areas, methods are being developed so that it can be determined whether a person is competent regardless of how and where he acquired the competency. Even then, we are really only saying that this individual has the potential to do a good job.

We have not yet done a very good job in the renewal of credentials. Licenses have generally been given for life. I think the attitude is moving toward more acceptance of the idea that we can no longer do that. Indeed, we need to have some kind of mechanisms for renewing that credential.

Just let me summarize that: As I see it, we are talking about the development of a quality assurance system. At this time it includes some imperfect back-up systems, some of which we may not eventually need. At this point in time, however, we're looking at accreditation as the process in the area of educational programs. We're looking at licensure, registration, or certification as processes which say something about the qualifications of the individual. We're beginning to look at renewal qualifications for that credential and somehow hopefully merging renewal requirements with on-the-job performance measures. Let me toss out some examples from the health field of where I see that renewal mechanism beginning to go. Certainly the one in the literature and the one with which I have most of my struggles in my State every day is the mandatory continuing education requirement. That particular concept (mandatory continuing education) is not directly linked to competency, and yet I have some practitioners in my State who have gone through 5-year renewal cycles, particularly in dentistry, who are saying they believe they could probably document that there is a relationship because it is beginning to look as if the individuals who are not meeting the renewal cycles are probably the same individuals the peers would determine not competent. At any rate, the one that is easiest and is probably catching on the quickest around the country is the continuing education requirement. Another example which all of you are generally familiar with is the Joint Commission on Accreditation of Hospital procedure for granting hospital privileges to physicians: Initially a physician presents himself with his credentials--graduation from an accredited school, licensed by the State, and so on. And yet, according to the new Joint Commission standards, he must have those privileges renewed based upon proof of competent practice through medical audit methods. So, in this example, there's a linking of a front-end credentialing with an on-going job performance.

At least two other examples that I know about have also recently emerged. My comments may not be well organized, but I believe they are basic and generic to this discussion.

THE STATUS OF CREDENTIALING IN THE STATES*

Introduction

The CSTAA, as a condition of its grant from NIAAA, was given the responsibility of assisting States in developing a system for the credentialing of alcoholism workers. The first task was to survey the States to find out where they were in the credentialing process. What we found was a range of activity

*Presented by Thomas E. Price

from operational systems to little or no action. A sense of concern, however, pervaded everywhere. Even States that had taken no action were alert to the issue and waiting for someone to give them direction on how to carry out their responsibility.

The States Mandate

The State's responsibility for regulations and standards which protect the public interest and control the quality of services is clearly mandated in PL 91-616, 93-282. Each State, as a part of its State Plan requirements to qualify for formula grant funds, shall:

> "...set forth, in accordance with criteria to be set by the Secretary, standards (including enforcement procedures and penalties) for (a) construction and licensing of public and private treatment facilities, and (b) for other community services or resources available to assist individuals to meet problems resulting from alcohol abuse."

Section 9 of the Uniform Law now adopted by twenty-five (25) States has this language:

> "The division (State Division on Alcoholism) shall establish standards for approved treatment facilities that must be met for a treatment facility to be approved as a public or private treatment facility..."

Since people are the primary tool or resource in the treatment of alcoholics any standards for quality services include provision of the competence of persons delivering the services.

Direction of State Credentialing Efforts

There is a remarkable degree of uniformity and consistency in the direction the States have taken in the development of their certification systems, especially those that have been developed in the last year. The concept of competency and utilization of the competencies identified in the Littlejohn Report have provided the basis for State initiated and organized efforts.

Further, the "certification issue" has provided a rallying point around which the alcoholism constituency has responded and organized. The State alcoholism program directors have consistently and conscientiously worked with constituency groups to ensure broad base participation in the formulation of standards and procedures for a credentialing system.

Given the level of credentialing activity in the States, which began in some State as early as 1972, CSTAA stepped into a rushing stream when it began its credentialing activities in late 1974. The decision of NIAAA not to support the concept of a national certifying body with State examining boards created apprehension. The major concern was the fear that the States would act in isolation and create 50 separate and widely divergent systems with little hope of reciprocity. This fear has proved to be unfounded.

Our survey revealed a remarkable degree of similarity. To encourage and foster this uniformity and standardization CSTAA developed a technical assistance package which provides guidance on how to proceed and what other States are doing.

We have encouraged States to refer to the Littlejohn report as a framework from which to work. Numerous site visits have been made to States requesting assistance on various specific problems. States repeatedly call on CSTAA for consultation.

In September 1975, the CSTAA membership adopted a Position Paper on "The Credentialing of Alcoholism Workers". That paper (distributed to the Planning Panel) defines basic terms, identifies some of the major issues, recommends alternative courses of action and provides a framework within which States can generate credentialing systems appropriate to their legislative requirements, administrative structures and program needs.

CSTAA has thus learned from what States are doing and has provided coordination and advice by sharing that experience with all States. The goals of the CSTAA project are to have credentialing available to counselors in all States as soon as feasible, to encourage a level of uniformity in the systems appropriate to the concept of the quality of care and allow at the same time for differences in States and their needs; to facilitate the geographical movement of counselors through uniformity of standards; to provide acceptance and recognition for the certified alcoholism counselor as a competent professional in the treatment of alcoholism.

Current Status of State Credentialing Programs

To summarize the current status of credentialing efforts in the States, the following chart shows how many States have operational systems and how many are at various stages along the way.

Operational	8
Near Operational	7
Working	21
Waiting to Start	20

Conclusion

Since credentialing of personnel is a responsibility that must be discharged at the State level, any national effort should evolve from and support the credentialing activity already taking place in the States. Means must be found to facilitate this effort and provide continuity.

ISSUES ON CREDENTIALING OF ALCOHOLISM COUNSELORS*

Third Party Payor Perspective

Introduction

Private third party (insurance companies and non-profit Plans such as Blue Cross) reimbursement for alcoholism treatment is a recent development relative to third party coverage for more conventional diseases. Although I am a novice in credentialing processes, I believe I reflect private third party payors in that respect.

*Presented by Susan G. Boynton

Credentialing is a small but significant part of the total health care picture and traditionally not a task involving third party payors. This is not to say credentialing is unimportant, but to point out from the third party payors' perspective that reimbursement has many factors to it which are not routinely the responsibility of the third party. We rely upon organizations whose specialty is credentialing to perform that function, just as we rely on professionals to deliver service, others to build and equip facilities, others to license them, others to accredit them, others to administer them. They in turn rely upon us to insure against financial loss due to illness or accident. However, the absence of a portion of this team affects the scope and level of reimbursement, and I am here today to assure awareness of the Panel and members of the field just what the private third party payor concerns are as they relate to credentialing of alcoholism counselors. There is no credentialing cookbook and I doubt the field really wants that. Yet I sense a groping for direction from people and organizations who represent legitimate concerns in alcoholism treatment.

Background/Third Party Payors

To orient you, there are 70 Blue Cross Plans in the United States, all private, distinct corporations. In some areas, one Blue Cross Plan serves the entire area. In others such as Pennsylvania, there are five Blue Cross Plans with distinct operating boundaries. Nationwide in 1973, 44% of people with private health insurance had Blue Cross and Blue Shield. The Blue Cross Association, located in Chicago, is the Plan's trade association. As such, it functions primarily in an advocacy role, coordinating activities such as quality control, national enrollment activities and as contractor for Medicare administrative functions. Participation by a particular Plan in BCA is voluntary.

Diversity

Private third party reimbursement of other than the medical model of detoxification for alcoholism is very recent and in many cases, still nonexistent. When I joined Capital Blue Cross in Harrisburg, Pennsylvania, two years ago, my assignment was to develop a benefit expansion program to take our individual Plan beyond benefits for hospital detoxification only. To educate myself on the issues, I participated in a treatment program, reviewed the literature and talked with people in government, people providing treatment and with alcoholics. I encountered a field very diverse in terms of treatment philosophy, partially the consequence of diverse backgrounds those delivering treatment bring to the field. That diversity, while in many cases accounting for much of the vitality in the alcoholism treatment field perhaps more so than other more formal areas of medical treatment, tends to create roadblocks for those third party payors interested in expanding coverage beyond hospital detoxification.

Absence of a recognized professional delivering service is one of those roadblocks. The questions then are, what would credentialing do to stimulate third party reimbursement and what are the issues in credentialing from the perspective of third party payors.

Quality of Care

The major concern is maximizing the relationship between quality care and the lowest cost. The quality of care issue for third party payors is a growing concern. Some insurance companies view themselves exclusively as payors of claims. In the health care field though, the relationship between the providers of service, the recipients and their representatives (third party payors) is

unique, and Blue Cross and Blue Shield at least believe they can do more to influence this relationship in a positive sense than merely process claims. However, with recognition that costs are rising quickly, increasing numbers of third party payors are concerned about what they can do, as the fiscal entity in health care, to assure quality of care relative to cost consciousness. Thus the government-mandated peer review program was developed. Also, many Blue Cross and Blue Shield Plans have been working in their own service areas on local peer review programs. For example, several years ago in Central Pennsylvania, Capital Blue Cross organized the Regional Medical Review Program with active cooperation of physicians. A rotating panel of physicians reviews claims on which the Plan and a particular hospital utilization review committee have disagreement in relation to appropriateness of admission, and over- and underutilization. Final adjudication of these claims is based on physician determination, not on Blue Cross determination.

Thus, quality of care issues are not new to most third party payors. Even so, to the extent we primarily are processors of claims, we must rely on existing and developing certification and accreditation efforts by appropriate organizations. These are not third party payors' responsibilities. We can and do demand credentialing from the professions delivering service but we cannot function in that role. It would be presumptuous of me to tell the field how we wanted credentialing or accreditation handled but we do expect it.

The effect of the JCAH alcoholism program accreditation has been significant. Indeed, I think it has been the singlemost important impetus in generating what little third party payor activity the field has seen in the last two years. But it would be misleading to assume that credentialing alone would have the same impact. The JCAH accreditation filled a vacuum and in many ways, it is being used for more than that for which it was originally intended.

Program Recognition

However, private third party payors would view credentialing as an ingredient, albeit fundamental, in what is more important--program recognition. Program recognition involves both accreditation and credentialing as they both contribute to assuring quality care and fiscal accountability.

Two years ago as part of our benefit expansion, Capital Blue Cross attempted to assess the free-standing alcoholism treatment providers in our 19-county service area, to assess whether or not a provider was capable of delivering quality care to our subscribers. We had very little to go on because the JCAH program had not been released and so I developed a survey tool by combining what I thought was the best from various site surveys and formats used by other organizations. It was kind of a lick and a promise when I put together that survey which I now, in light of the JCAH activities, consider rather elementary. One of the things we sought was a listing of all treatment personnel and their backgrounds. Frankly, we really didn't know what to do with it then and I'm not sure we would today. Thus, even with JCAH accreditation, third party payors are not the appropriate entities to assess qualifications of those delivering service.

In assessing potential providers, we looked at other aspects of treatment programs such as treatment philosophy, the length of treatment, excessive treatment, evidence of sound fiscal and administrative management, ratio of

counselors to patients, etc. Obviously, credentialing is a thread and personnel quality is a thread, but a common thread which runs through all this and gets back again to the relationship between quality care at the lowest cost.

What can Credentialing do?

In terms of reimbursement, third party payors are geared to deal with institutions, not individuals. Given the diverse treatment programs though, there are difficulties in stimulating a broad response by third party payors and increasing their involvement with free-standing facilities treating addicts. Credentialing can do two basic things to facilitate this response. One is to assure minimum standards, and the other is to assure these standards on a broad basis. Whether that should be statewide or national, is really up to the field. The reason I made the point about 70 Blue Cross Plans is that while we may eventually end up with some form of National Health Insurance, at this time the response by third party payors is generally on a Plan-by-Plan or at least a state-by-state basis. The enabling legislation creating Blue Cross and Blue Shield varies from state to state. In certain states, the Blue Cross Plan(s) may contract with acute general hospitals only. In other states, Blue Cross Plans have more or less a free hand to decide what facilities they will reimburse.

There are two additional reasons I urge some kind of a broad standard for credentialing. First, Blue Cross has what we call an Inter-Plan Bank system, which assures for example, a subscriber from the District of Columbia hospitalized in Iowa that the services received will be covered. The Inter-Plan Bank involves reciprocity agreements between Plans to recognize each other's providers and to pay claims through that mechanism. One problem we have had since recognizing our alcoholism providers were queries from other Blue Cross Plans on behalf of their subscribers. Is this facility a general hospital? What is it? While the response has been excellent in terms of out-of-area Blue Cross Plans covering their subscribers who utilize our treatment facilities, some Plans have refused to honor our recognition of the alcoholism providers as members which qualifies the facilities to have claims processed through the Inter-Plan Bank. If credentialing and accreditation will help to standardize treatment and treatment facilities so that Blue Cross Plan of Ohio can be assured that the Blue Cross Plan of Pennsylvania is dealing with an institution with which they would also want to deal, there will be fewer claims rejected because they did not or could not recognize a particular type of facility. The same is true of commercial carriers.

The second reason for establishing a mechanism to assure broad minimum standards in treatment is for benefit reciprocity. Many national corporations have plants or branches in more than one state. The federal government could be an example here. That corporation or union selects the insurance package for its employees with varying rates of employee contributions toward premiums or rates. When a third party payor offers a new benefit program to the employees, one of the first questions asked is whether the employees in other states will be able to obtain the same type of care. In other words, the corporation or union does not want to buy the new benefit unless they can be sure their employees in one state will have available the same services in another state.

Summary

These are the major reasons that broad standards for treatment and thus credentialing are important in dealing with third party payors. I have emphasized

program recognition because I believe it is premature to talk about individual reimbursement for counselors. At the present time--and this is a personal opinion--politically, individual reimbursement is still very much a doctors' ballgame. More rapid results will come about through program reimbursement rather than individual turf reimbursement. I will be happy to answer any questions you might have at this time.

Question: How many Blue Cross Plans cover alcoholism?

Boynton: Most Blue Cross Plans and most commercial carriers cover alcoholism in that they cover detoxification at a general hospital. The eight or nine Blue Cross Plans and those commercial carriers that cover additional types of treatment have widely differing benefits. For example, Capital Blue Cross covers rehabilitation in approved, free-standing residential treatment programs. We do not cover outpatient treatment yet because of the diversity of outpatient programs. Blue Cross of Maryland has an inpatient and an outpatient benefit package and Blue Cross of Delaware has a residential benefit. Blue Cross/Blue Shield of Michigan has recently developed a national benefit program for GM employees, recognizing all levels of care. A requirement in the General Motors package is that the programs eligible for reimbursement be JCAH accredited. I believe that makes the JCAH accreditation do more than it was intended to do, but General Motors and Blue Cross had little else to rely upon to extend the benefits on a national basis.

Question: From what you say, I gather that Blue Cross does not pay for counselors. They only pay for detoxification....(garbled)

Boynton: Blue Cross reimburses hospitals, facilities and as such, facility-based professionals if their salary is paid by the facility and the professionals do not bill the patient for service. Blue Shield reimburses for professional services directly to the physicians. Thus, Blue Cross does not reimburse counselors directly. My Blue Cross Plan does cover counseling as it occurs in a rehabilitation program, but we pay an all-inclusive rate to that provider. The treatment staff is considered provider-based since their salaries are paid by the facility. They are not individually reimbursed the way a practicing physician would be reimbursed.

Question: So you do pay for counseling of a sort.

Boynton: Indirectly through the facility, yes.

Question: But for the most part, the third party recognition involves treatment of the acute situation.

Boynton: This is true. We have begun in most cases with covering the more acute levels of care.

Question: Is it true that in Minnesota Blue Cross has an alcoholism benefit program?

Boynton: I can't answer the question. I don't believe that Minnesota has a benefit at this point. Another thing you'll find is that the Blue Cross Plans and probably the commercials that were thinking about going ahead with some kind of a benefit probably have done so. What are left are those Plans and commercial carriers who pay only hospital claims or

who perhaps want to provide benefits but their financial reserves are such that they don't feel they can finance a new program until those third parties providing the benefits have developed a data base upon which to price the risk.

Question: On that issue, do you specifically include an alcohol benefit in a specific package or does it apply to the entire population in your Capital group?

Boynton: At Capital Blue Cross, we did not market a special benefit, but made it available to our Comprehensive and Direct Pay contracts as a basic benefit. Employer-negotiated groups have to be negotiated individually. We felt even without a rehab benefit, the Plan was paying for alcoholism anyway--under other diagnoses. Because of lack of treatment, people ended up in the hospital with other diseases exacerbated by the alcoholism. A family physician, who has the prerogative to protect the patient, sometimes admits alcoholics under other diagnoses to protect personal reputations or so they can receive third party coverage. We did an informal computer survey of subscribers who were hospitalized in 1973 with an admission for detoxification (so we knew they were bona fide alcoholics) and then ran a claims history on them. Results were very interesting; one subscriber had $12,000 worth of hospital bills (7 admissions) in one year. Others were hospitalized less frequently with everything from bronchitis to cirrhosis to ulcers and psychiatric problems. Thus, we knew we were paying for alcoholism indirectly. Our Plan is very fortunate in that it has sufficient reserves to support experimental programs and that the Board of Directors was willing to approve the recommendations that we make alcoholic rehabilitation in approved facilities a basic benefit at no initial additional cost to the subscriber.

Maryland Blue Cross, on the other hand, took the same data and came up with a rate of $0.63 per family contract for the subscriber and spouse only per month. They began marketing their residential care benefit and I believe they now have about 100,000 subscribers enrolled. Maryland Blue Cross found, as we did, that the utilization of the benefit was low enough that they extended the benefit to dependents at no additional rate. These differing responses illustrate that very little actuarial information was and is available and third parties are in a position of guesstimating their risks.

Question: This is what I'm trying to get at, whether the experience over the years has been favorable or unfavorable or what we could look forward to as a prognosis for inclusion of that as a benefit.

Boynton: The Blue Cross Association is interested in those Plans that are gathering data. However, actuaries are, as you know, by nature extremely conservative. They are dealing with somebody else's money and Capital Blue Cross in making the benefit available at no additional cost was really the maverick in the field because just about everybody else is marketing a specific benefit and charging a specific rate. I think a lot of people are watching us to see what happens. Due to the low rate of utilization, actuarial data are being generated slowly. Plus, timespan is a necessary factor in setting rates, especially when dealing with a disease with the known characteristic of recidivism.

Question: Would you describe the process or pressures by which Blue Cross or a third party payor decides to look into a new benefit package.

Boynton: There are three basic pressures working together. First, some of it comes internally. In our organization, management had been aware for some time that we were probably paying for alcoholism. But we needed staff to do the work to get a proposal down on paper because you just don't go to a Board of Directors with a request like that; you must have everything mapped out. Another pressure would be from unions and employers who purchase health care coverage for their employees. They come to their third party payors and are in a position to say "we want to buy certain specific benefits in addition to the basic package". And I think in a sense that third party payors want to be, must be responsive to their customers, the pressure generated that way is probably one of the most important factors of all.

A third factor is mandatory legislation, or threat of it. In certain states, legislation has been enacted mandating alcoholism benefits or in some cases mandating mental health benefits and then including alcoholism and drugs in that. I understand that in many states where this was done, the states weren't ready, the programs weren't ready, and/or the people weren't ready. At our hearing in November with the Pennsylvania State Legislature on the possibility of mandating benefits, people representing programs in favor of legislation did not really know results to date in states which have mandated coverage.

Question: Let's hypothetically assume that tomorrow morning at 7 o'clock, there is a nationwide consensus on credentialing of alcoholism counselors which would automatically then be put in as part of a program for direct payment of benefits, how long do you think it would then take for the third party payor, or Blue Cross specifically to go ahead and accept this as a coverable item?

Boynton: I'm guessing, but I think it would be some time. That's why many Plans have gone their own route. Other Plans wait for a package design to come from BCA to help them set the benefit up. It also depends on whether or not enabling legislation would allow Plans or commercial carriers to contract with other than acute general hospitals. So it isn't much of an answer for you but its really because I'm not sure.

Question: Are you knowledgeable about any plan for a third party program in alcoholism that would be nationwide? For example as a pilot, as a member of an association, I'm entitled to certain health programs.

Boynton: At this time, there are negotiations going on between the Blue Cross Association and NIAAA for grant funds to market on an experimental basis at test sites, a broad alcoholism benefit package. What the status of that proposal is, I'm not sure. There is something on the order of a three-year timetable from the start of the project to its finish; I may be wrong about the exact time. We're talking about years, not months though, and what the result of that program will be is anyone's guess.

Question: Is there anyone here from NIAAA knowledgeable about this.

NIAAA: I can speak for that issue, (garbled).... In NIAAA, we currently have a contract proposal (garbled)....Blue Cross Association. I think Susan described some of the components of that. Basically, the first year of that proposal which is planning surveys in which BCA would try to

accumulate a data base of what's happening in the 70 or so Blue Cross Plans and then follow that up with a field test of a benefit package, or perhaps several benefit packages and selective locations. Now those packages, we're hoping and we think you should look for those packages to be very broad-based benefits. One of the problems we've had with insurance benefits today is that the package has been a very narrow one. Limited largely to detoxification services and we're very keen on opening that package up both in the Blue Cross sector and commercial carrier sector to a broad-based....of alcoholism services. Counselors who are working in the alcoholism field will feel free and will be available to move across a full constellation of services within that package. When that will eventuate is anyone's guess, we're hoping that the present survey can move forward within the next few months and that we'll be into field testing after that with some additional work.

Question: Is the Health Insurance Association of America which represents the commercial carriers also involved with the grant, or was there one under consideration by NIAAA?

NLAAA: There is currently in the Institute a grant proposal for Health Insurance Association of America, that's a national membership organization of some 320 commercial carriers, the major carriers of this country and we are looking into that proposal in terms of some of the similar kinds of things we're looking for from BCA. In other words, the commercial carriers are saying to us that we do not have enough experience, we do not have enough data on which to install the kinds of packages it seeks to build that data base with commercial carriers and would also move into a selective field test of packages so that we would have (1) the data base and (2) the actual field test experience.

Question: Many of us gather data in a retrospective fashion, I think we've got an identifiable group to work with here, is that part of your program to go back in time and do a retrospective study as opposed to systematic data gathering?

NLAAA: We're doing both of those proposals, we're doing a retrospective study, we're looking at the selective (garbled)...experiences, or we will be; in Capital Blue Cross, in Maryland, in the California Blues and we will also be accumulating data in terms of future projections. There is also a whole host of what we call support, the kinds of factors that are necessary to the insurance industry in terms of things like cost forecasting methodology, how to market the benefit. I think Susan spoke about the under-utilization, that's a real problem. We know with Kemper and some of the other carriers that just making the benefit available does not mean people are going to necessarily utilize it. And we still have to grapple with the stigma that getting people to accept that the utilization of that benefit is no different than utilization of any other benefit in the insurance package. So we're going to be developing hopefully marketing materials, cost forecasting methodologies that we can give to actuaries who are telling us now that we really cannot get a handle on how (garbled).... In fact the California experience is pretty much a top of the head experience from the carriers themselves there, they really had no in-depth data base and the idea was that they would go ahead with premium rates the first year and if those premium rates were way out of hand, they would somehow modify them one way or another.

ALTERNATIVE A

I. PURPOSE: To develop a national registry system which will:

—insure visibility and creditability for the alcoholism worker.
—assure uniformity and competency to the employers.
—provide accountability to protect the interests of clients and the public.

II. FUNCTIONS:*(see page 19)

1. Establish standards for State certifying bodies. Serve as an agent to advise on standards and processes in the establishment and operation of new certifying systems in the States.

2. Conduct research, study the methodology of evaluation and testing, construction and validation, so that certification systems reflect competency in the performance of the role of the alcoholism counselor.

3. Collect and disseminate information. Compile data on manpower resources for the treatment of alcoholics; information on the education, training and experience of currently certified counselors, which would provide guidelines for the continuing development of education and training activities.

4. Provide for mediating cooperative and joint activities whereby the State certification organizations, and other parties at interest can review and coordinate initial and continuing certification requirements; mediate differences arising from a need to certify new specialties or to work through the difficulties of integration of alcoholism and drug abuse services.

5. Perform a public relations and representation role. Serve as a common communications arm to the various legislative and administrative government agencies which have an affect on certification. Among the pertinent issues which are included in such a function are:

   a. image creation for the public, showing the alcoholism counselor as a skilled professional worthy of public confidence.

   b. to gain recognition and acceptance for the alcoholism counselor from "other professionals" in allied health services.

   c. recognition of the public's interest in alcoholism counselor competence, as reflected in certification and translation into policy guidance for State certifying organizations.

III. STRUCTURE:

Create a representative GOVERNING BOARD.

Options:

1. By invitation of the NIAAA Planning Panel and the cooperative effort of the National Alcoholism Organizations.

2. By invitation of a single organization and the cooperative effort of the National Alcoholism Organizations.

The originators of this alternative believe that in terms of accountability Option 2 would have the obvious advantage of continuity since the NIAAA Planning Panel has a limited function and life span. Option 2 would make the Governing Board not only responsible to an organized constituency but also to the public, to the States, and to the Federal Alcoholism Agency. It would increase the accountability without limiting the openness of the process or the autonomy of the organization.

ALTERNATIVE B

I. PURPOSE:

1. To establish a new private, nonprofit corporate entity, independent from but representative of existing organizations in the alcoholism field.

2. This organization will be concerned only with the certification of alcoholism counselors and related credentialing functions but with the clear understanding that it will not conduct its activities in isolation from drug abuse and/or addiction counselor efforts nor is it precluded from being a part of a broader organizational effort should such a broader counselor structure be indicated in the future.

3. This organization will be responsible for developing and maintaining national standards for use by non-governmental organizations in a program of voluntary certification at the State level.

II. FUNCTIONS:*(see page 19)

The functions of the organization should be those developed by the NIAAA Panel based on those stated in the "Feasibility Study of a Voluntary National Certification System for Allied Health Personnel". In addition, the development of standards for State certification organizations and conditions of recognition of these organizations by the national organization should be added as a function.

III. STRUCTURE:

This organization should be structured so as to provide for maximum input from experts in areas such as education and training, credentialing, health insurance and others as appropriate.

The actual structure of State level organizations should be left to the States. However, these organizations must also be independent bodies with professional credibility and integrity. The national organization should develop minimum standards for these organizations as a condition for recognition as the State certifying body.

The Board of Directors should consist of a minimum of twenty, one each from the fifteen organizations listed in Tab A and five employed counselors. While a minimum is suggested, a larger number may be desirable since the Board will be essentially a working board, responsible for major tasks in getting the organization into operation. The Board of Directors will be responsible for overall policy and direction of the organization. The by-laws should stipulate a specific transition period and process for election of new members. The non-counselor board members should be rotated off the board over a period stipulated in the by-laws and replaced by representatives from State certification organizations. (See Advisory Committee below). The period of this transition should be tied directly to the progress made in establishing recognized State certifying bodies.

The Board should appoint a certification committee consisting of a majority of employed counselors. Other members should include representatives from pertinent areas such as AAETPs, health care providers, and State alcoholism authorities. A minimum of twenty total members is suggested. This committee would be responsible for the development and maintenance of national standards.

Advisory Committee

To ensure maximum input from relevant and interested organizations and to provide for meaningful balance to the inherent professional self interests of the organization, an advisory committee to the Board of Directors should be established. The membership of the committee should include representatives from organizations on the initial Board of Directors after they have been rotated off the Board.

Operating Committees of the Board of Directors

In addition to the certification committee, committees should be established to correspond to each of the other basic functions of the organization. Membership should be primarily Board members but non-Board members should also be considered to provide for broader input. The committees would make recommendations regarding the organization's policies and programs in each functional area for approval by the full Board.

ALTERNATIVE C

I. PURPOSE:

1. Establish and maintain standards for certification.

2. Maintain a register of counselors certified under standards accepted by the National Board.

3. Develop an accreditation program for education and training for the profession.

4. Monitor and offer technical assistance in the operation of the affiliated alcoholism counselors' certification systems.

II. STRUCTURE:

A. Initial Board of Directors - twenty-four members selected from national organizations that have an interest in developing the profession and eight from the offices of affiliated organizations of alcoholism counselors. Membership from national organizations to be rotated out over a two-year period to be replaced by representatives from affiliated credentialing organizations of alcoholism counselor in such a fashion as to establish geographic and ethnic representation on the board. The majority of the Board of Directors must be paid full-time qualified alcoholism counselors.

Functions and Responsibilities - Board of Directors

1. Select the peer review board.

2. Provide a place for the organization.

3. To arrange for meetings of the constituent bodies of the organization.

4. To develop an initial fee structure for the operation and a financial program for the operation of the organization.

5. To organize a viable register that can be used for reference and analysis.

6. Provide service to the peer review board and assist in the implementation of the decision of the Review Board.

B. Peer Review Board, selected by the Board of Directors from certification boards from candidates proposed by nominations committees of credentialing associations, all members for two years, except one-half of the initial board who shall serve for one year.

TOTAL	32
Certified Counselors	20
Five from each AAETP Region with appropriate minority representation	
Professional Health Service Providers	4
State Authority Representatives	4
Public and Law	4